Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management - Utilization Management**		**SUBJECT (Document Title)** **Utilization Management Clinicians Responsibilities (Health Plan/Region)**	
Effective Date 09/16/2009	**Date of Last Review** 07/25/2019	**Date of Last Revision** 04/29/2020	**Dept. Approval Date** 04/29/2020
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☒ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To identify the responsibilities of the Utilization Management Clinician within Health Care Management.

DEFINITIONS:

Clinical Criteria and Guidelines: The health plan/region primarily utilizes current editions of applicable Company Medical Policies and Clinical Utilization Management (UM) guidelines, InterQual® Level of Care criteria, MCG Care Guidelines (formerly known as Milliman Care Guidelines), The Centers for Medicare & Medicaid Services (CMS) criteria and state specific guidelines as applicable, to review the medical necessity and appropriateness of both physical and behavioral health services. Clinical criteria and guidelines are used by Health Care Management (HCM) UM clinicians to determine whether to approve the requested treatment or to review with the health plan/regional Medical Director for determination.

PROCEDURE:

UM Clinician responsibilities may include the following functions as determined by each health plan/region clinical leadership:

1) Performs technical and administrative work required to evaluate the necessity, appropriateness, and efficiency of medical services, procedures, and facilities:
   a) Home Health Care
   b) Home Therapy (Physical, Occupational and Speech Therapy)
   c) Durable Medical Equipment
   d) Non-Participating Provider Requests
   e) Specialty Injectables
   f) Air Transportation
   g) Transfer/Placement to Free Standing Skilled Nursing Facility/Rehabilitation Center
   h) Out-of-State Transfers for Inpatient Admission

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2) Performs inpatient medical necessity and concurrent reviews and coordinates with the discharge planning team members, facility UM departments, physicians, and members to coordinate timely discharges. Provides appropriate referral and scheduling assistance.

3) Identifies and reports quality or utilization issues to the health plan/regional Medical Director.

4) Participates in a multi-disciplinary clinical team to achieve positive member outcomes.

5) Participates in rounds with the Medical Directors.

6) Utilizes effective customer service principles to assist internal and external customers.

7) Participates in Quality Improvement processes.

8) Maintains member confidentiality.

9) Documents all activities in the appropriate medical management system on a timely basis.

REFERENCES:

Kentucky Medicaid Managed Care Contract §21.1, 21.2, 34.8
Kentucky Revised Statute 304.17A.607
Texas UMCC Att B-1 Section 8.1.8

Prior Procedure Reference(s):
UM Clinicians Workflow Process - SBS

Related Policies and Procedures
A20 Authorization/Pre-certification for Medical Injectables through Pharmacy Department
Concurrent Review (Telephonic and Onsite) and Onsite Review Process - Core Process
Coordination of Care Between Behavioral Health and Medical Management
Health Care Management Denial Core Process – KY
Out of Area-Out of Network Care
Out of Network Authorization Process
Pre-Certification of Requested Services – Core Process
Utilization Management Clinicians Responsibilities - DC

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management - Utilization Management

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EXCEPTIONS:

Kentucky:
The UM program, processes and time frames are in accordance with 42 CFR 456, 42 CFR 431, 42 CFR 438 and the private review agent requirements of KRS 304.17A as applicable.

Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts.

The health plan primarily utilizes current editions of InterQual® Criteria for Medical Necessity for both physical health and behavioral health services, except that the health plan utilizes the American Society of Addiction Medicine (ASAM) for substance use and AIM Clinical Guidelines for radiology benefit management per approval from the Department. If InterQual® Criteria does not cover a behavioral health service, the health plan utilizes the following standardized tools for medical necessity determinations - for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII). If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the health plan shall submit its proposed medical necessity criteria to the Department for Medicaid Services (DMS) for approval. The Department may also, at their discretion, require use of other criteria they create or identify for services or populations not otherwise covered by the aforementioned criteria/guidelines. The Health plan will be given ninety (90) days to implement criteria the Department may otherwise require.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness of services across the continuum of care: prospectively, concurrently and retrospectively.

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The health plan has in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director supervise the UM program and are accessible and available for consultation as needed.

For behavioral health discharges, the Telephonic Concurrent Review Clinician also makes certain the member has a follow-up appointment within seven (7) days of discharge and documents the location, time, and practitioner in the discharge notes.

REVISION HISTORY:

Review Date	Changes
11/12/2013	• Off-cycle review to add Virginia as an applicable market. Add VA exception and move to MBU template.
01/01/2014	• Added Kentucky health plan.
09/02/2015	• Reviewed for LA Bayou Health Contract Amendment 4
12/03/2015	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
02/25/2016	• Biennial review by PPOC and MOC • Added region(al) to process responsibilities • Revise definition of Clinical Criteria and Guidelines • Updated References section • Added FL, KY and TX exception language • Revised VA exception language • Removed TN exception language
03/13/2017	• Off-cycle edit to KY exception language
04/27/2017	• Annual review • WNY added as an applicable market • Removed plan appeals review from policy • Updated Related PorPs
05/26/2017	• Off-cycle edit to remove MMP as an applicable product • Added Medicaid-Medicare exception
11/08/2017	• Off-cycle edits to add IN as an applicable market and add IN exception language
06/28/2018	• Annual review • Wordsmithing to Procedure section • Revised References • Revised IN, KY & LA exception language; added IA exception

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	language
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
11/09/2018	• Off-cycle edits – revised exception languages for KY, TX & VA
01/25/2019	• Off-cycle edit to add AR as an applicable market. No content edits.
07/25/2019	• Annual Review • Placed on updated template • Added DC as an applicable market • Updated Policy section • Updated References • Revised FL, KY, MN & TX exceptions
08/16/2019	• Off Cycle Edit • Update to TX references and exception language
02/07/2020	• Off-cycle review for new LA Emergency Contract; revised LA exception
04/29/2020	• Off-Cycle Review • Revised KY exception language • Updated KY references

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